



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECLIPSE MEDICAL IMAGING
SUITE 407
6805 NORTHEAST LOOP 820
NORTH RICHLAND HILLS TX 76180

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative

Box Number 53

MFDR Tracking Number

M4-10-4554-01

MFDR Date Received

June 29, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received a request for a refund in the amount of \$434.37 for our patient [injured employee] for her date of service May 18, 2009. In accordance with DWC Rule 133.260 (a) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided. The request was received by fax with Cody Copeland with Arkansas Claims Management, Inc. on May 27, 2010 [sic] which is outside the guidelines for a refund request pursuant to this rule. When speaking with Mr. Copeland, he stated there was a request sent in January but he couldn't provide any form of confirmation when I requested it and transferred me to his manager Reyna. She also stated they could not provide any confirmation of when the original request was made. Attached is the correspondence between Arkansas Claim Management, Inc. and Eclipse Medical Imaging. Given that we have no prior requests on file and they cannot provide verification that they sent the request any earlier I am filing for Fee Dispute Resolution. I can be reached at the numbers listed below for any further information regarding this dispute."

Amount in Dispute: \$434.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The health care provider was notified within 240 days from the date of service regarding the refund request. The carrier initially submitted the attached reconsideration on 01/06/10. This was communicated to the HCP on 05/27/10. The follow up written request was submitted on 05/26/10. We are again requesting that the HCP remit a refund in the amount of \$434.37. Also, see Rule 102.4(h) regarding when written communication is deemed to be sent."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2009	72148 and 76376	\$434.37	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.260 sets out the procedure for refunds.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W5 – Request of recoupment for an overpayment made to a health care provider
- 160 – Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion
- 5128 – Refund processed by RSL
- 5079 – Overpayment recoupment
- 5075 – Charge unrelated to compensable injury

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

The date of the services in dispute is May 16, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 29, 2010. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B).

The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 18, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.